



# WASATCH MEDICAL CLINIC

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NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

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No. \_\_\_\_\_

SIG:

REFILL \_\_\_\_\_ SIGNATURE \_\_\_\_\_

BNDD No. Pitts AP6171742

Burton AB 6569365

McDonald AM 7665233

NOTE TO PHARMACIST:

Label all prescriptions and may refill enough to last until next clinic day.

